Immunoglobulin Therapy

Member and Medication Information (required)	
Member ID:	Member Name:
DOB:	Weight:
Medication Name/ Strength:	Dose:
Directions for use:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Please circle the indication and medication and submit all supporting documentation.

	Primary humoral immunodeficiency	Immune thrombocytopenic purpura	Chronic inflammatory demyelinating polyneuropathy	B-cell chronic lymphocytic leukemia	Kawasaki disease	Multifocal motor neuropathy
Preferred						
Gammagard S/D (IVIG)	2 years and older	18 years and older		18 years and older	5 years and older	
Gammagard Liquid (IVIG, SCIG)	2 years and older					18 years and older (IVIG only)
Gamunex-C (IVIG, SCIG)	2 years and older	No age minimum (IVIG only)	18 years and older (IVIG only)			
Gamastan Gamastan S/D (IVIM)	❑ Prevent or modify measles in susceptible person ❑ Prophylaxis pre or post exposure to hepatitis A ❑ Modify varicella in susceptible person ❑ Modify rubella in exposed women who will not consider a therapeutic abortion					
Non-preferred *(Non-preferred products, per Utah Medicaid's PDL, require trial and failure of a preferred Immunoglobulin Therapy product or the prescriber must demonstrate medical necessity for non-preferred).*						
Asceniv (IVIG)	12 years and older					
Bivigam (IVIG)	6 years and older					
Cutaquig (SCIG)	18 years and older					
Cuvitru (SCIG)	2 years and older					
Flebogamma DIF (IVIG)	2 years and older	2 years and older				
Gammaked (IVIG, SCIG)	2 years and older	No age minimum (IV route only)	18 years and older (IV route only)			
Gammaplex (IVIG)	2 years and older	18 years and older				
Hizentra (SCIG)	2 years and older		18 years and older			
Hyqvia (SCIG)	18 years and older					
Octagam (IVIG)	6 years and older	18 years and older				
Panzyga (IVIG)	2 years and older	18 years and older				
Privigen (IVIG)	3 years and older	15 years and older	18 years and older			
Xembify (SCIG)	2 years and older					

Criteria for Approval: (ALL criteria must be met for ALL requests)

- ❑ Documented diagnosis of requested indication. Chart note page #: _____
- ❑ Laboratory results supporting the indication for requested immune globulin, if applicable. Chart note page #: _____
- ❑ Treatment plan including monitoring described in detail. Chart note page #: _____
- ❑ Prescribed by or in consultation with specialist associated with disease state. Chart note page #: _____

Additional Criteria for Primary Immunodeficiency: (ALL criteria must be met for approval)

- ❑ Documented diagnosis of sub categories of primary immunodeficiency. Chart note page #: _____
- ❑ Labs confirmed specific antibody deficiency. Chart note page #: _____

Additional Criteria for Immune thrombocytopenic purpura:

- ❑ Labs confirm platelet counted. Chart note page #: _____
- ❑ Acute treatment for rapid increase in platelet count is necessary:
  - Bleeding episode
  - Prior to surgery
- ❑ Chronic non-life-threatening ITP:
  - Trial and failure of corticosteroids or contraindicated. Chart note page #: _____

Additional Criteria for Kawasaki disease:

- ❑ Fever more than 5 days. Chart note page #: _____
- ❑ Have more than 4 principal clinical features described in chart note. Chart note page #: _____
  - Bilateral conjunctival
  - Erythema and cracking of lips, strawberry tongue and/or erythema of oral and pharyngeal mucosa erythema and cracking of lips, strawberry tongue, and/or erythema of oral and pharyngeal mucosa.
  - Cervical lymphadenopathy
  - Erythema of palm and sole
  - Rash

Additional Criteria for Chronic inflammatory demyelinating polyneuropathy:

- ❑ Trial and failure of corticosteroids or contraindicated. Chart note page #: _____

Additional Criteria for Gamastan: (ONE criterion must be met for approval)

- ❑ Hepatitis A:
  - Exposure is less than 2 weeks. Chart note page #: _____
- ❑ Measles:
  - Exposure is less than 6 days. Chart note page #: _____
  - Patient has not been vaccinated nor had measles previously. Chart note page #: _____
  - IVIG NOT given at the same time with vaccine. Chart note page #: _____
- ❑ Varicella:
  - Patient is Immunosuppressed. Chart note page #: _____
  - Rationale of not giving VariZIG. Chart note page #: _____
- ❑ Rubella:
  - Pregnancy. Chart note page #: _____

Off Label Use Additional Criteria:

Immunoglobulin requests for off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, American Academy of Allergy, Asthma and Immunology or other peer review specialty medical journals. Supporting documentation must be included.

Re-authorization Criteria: Updated letter of medical necessity or updated chart notes demonstrating positive clinical response

Initial Authorization: Up to six (6) months
Re-authorization: Six (6) months

Notes:

- ❖ Use appropriate HCPCS code for billing
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php
- ❖ The patient must have regular appointments to receive the medication in the prescriber's office. The patient must remain in the office for a minimum of 90 minutes to allow for observation and treatment of anaphylaxis, if necessary. If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date